DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS: Keith T. Downing: Nothing to disclose; Ava R. Leegant: Nothing to disclose; Stephanie Morgan: Nothing to disclose; Siobhan M. Dolan: Nothing to disclose; Greg S. Boutis: Nothing to disclose.

96 What is the utility of routine intraoperative X-ray to identify retained foreign objects in obese patients undergoing abdominal gynecologic surgery?

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OBJECTIVES: To evaluate the effectiveness of routine intraoperative x-ray to identify unanticipated retained foreign objects in obese patients undergoing abdominal gynecologic surgery.

MATERIALS AND METHODS: This was a retrospective cohort study of obese women who underwent abdominal gynecologic surgery at a tertiary care academic institution from 2010 to 2015. Women with a BMI greater than or equal to 35 kg/m^2 who underwent gynecologic surgery and had an intraoperative abdominal x-ray per our institution's protocol were included. Per this protocol, all patients had a series of abdominal x-rays taken in the operating room immediately post-operatively prior to waking from anesthesia. Subjects who underwent a routine intraoperative x-ray were compared to similar subjects from our sister community hospital who did not have an intraoperative x-ray. The primary outcome was identification of an unanticipated retained foreign object. Additional information including patient demographics, indication for surgery and post-operative course was extracted from the electronic medical record. Baseline information and results were assessed with univariable generalized linear mixed effect model and an exact logistic regression model.

RESULTS: Two hundred fifty-nine of 308 women met inclusion criteria. Of these, 243 (93.8%) received a routine intraoperative x-ray and 16 (6.2%) did not. There was no statistical difference between the two groups of patients in terms of age, race, BMI, type of surgical procedure, length of surgery, whether or not the surgery was converted to open after minimally invasive approach, or whether or not unplanned procedures or surgeons were involved. There were no retained foreign objects identified by routine x-ray in this cohort of patients. There was also no significant difference in other post-operative outcomes including odds of developing a post-operative infection (OR 2.86, CI 0.39-22.32, p=0.31) or odds of reoperation (OR 2.00, CI 0.34-11.61, p=0.44). There was a significant difference in the time spent in the operating room after surgery was completed (31.8 v. 10.9 minutes, p=0.046), with the x-ray group spending on average 20.7 minutes more in the operating room after surgery was completed. The median number of x-rays performed was 3 (range 2-10). The estimated associated average cost of the x-rays was $1487 per patient. The estimated average cost to the hospital of additional time in the operating room was $1122 per patient, with total costs to the hospital for this cohort estimated at $272,799.

CONCLUSION: A routine intraoperative x-ray for obese patients undergoing abdominal gynecologic surgery did not detect any retained foreign objects, and there were no differences in post-operative outcomes. There was significantly more time spent in the operating room and higher costs associated with patients who had a routine intraoperative x-ray.

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97 Correlation of self-reported surgical volume with performance of procedural tasks on the laparoscopic simulator

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OBJECTIVES: The objective of the study was to determine how performance on laparoscopic simulation procedures correlate with case volumes and fellowship training in attending obstetricians and gynecologists.

MATERIALS AND METHODS: All obstetricians and gynecologists with laparoscopic privileges at a single institution were required to complete a pre-test survey and tasks on the Surgical Science LapSim laparoscopic simulator. The assessment was completed by 80 physicians with a median of 15 years in practice and included both generalists (76%) and fellowship-trained specialists. All participants completed a questionnaire about prior training and their average monthly laparoscopic case volumes. They then performed peg transfer and ectopic pregnancy salpingectomy tasks on the simulator. Correlations between the survey responses and the time, blood loss, and economy of movement for each task were statistically assessed using spearman correlation and Wilcoxon tests.

RESULTS: Surgeons with higher self-reported surgical volume (6-10 cases per month and 11+ cases per month) completed the salpingectomy tasks more quickly than those who operated less often (0-1 and 2-5 cases per month; p=0.002). Those with higher surgical volumes also had less blood loss (p=0.03). Instrument path length was significantly lower in high volume surgeons as compared to low volume surgeons (p = 0.002). Those who had fellowship training also had decreased total time and blood loss in the salpingectomy task compared to those who had no fellowship training (p = 0.008 and 0.07, respectively), as well as a decreased instrument path length (p = 0.004). There was no difference in ovarian tissue thermal damage between fellowship trained and non-fellowship trained surgeons (p = 0.99). In the peg transfer task, high volume surgeons and those with fellowship training had lower instrument path length (p=0.02 and 0.06, respectively) compared to low volume and non-fellowship trained surgeons.

CONCLUSION: Surgeons who operate more frequently performed the salpingectomy task on the simulator more quickly, possibly due to more economical movements, which is indicated by lower instrument path length. These efficient movements may result in lower blood loss during the procedure. Experience gained by either large surgical volume or fellowship training correlate with higher procedural scores on the simulator.

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98 Global climate change: Decreasing hot air emissions at the SGS annual clinical meeting

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OBJECTIVES: To evaluate time "lost" associated with oral, oral poster, and video presentation introductions and pleasantries at the SGS annual clinical meeting.
MATERIALS AND METHODS: The 2017 SGS abstract supplement was reviewed and the median word and character counts for titles of oral, oral poster, and video presentations were collected. Titles in each category that were equal to the median were identified and utilized for timing analyses. A standardized script for presenter introduction and pleasantries was created. This included the presenter name, current position and hospital affiliation. Additionally, it included a disclosure statement and a sentence thanking coauthors and the society for allowing them to present their research/video. Six physicians were instructed to read the script aloud as if standing at the presenter podium and timing was recorded. They were also timed when verbalizing a variety of oral, oral poster and video presentation titles. This was used to calculate overall meeting time utilized.
RESULTS: Seventy-five presentations from the 2017 SGS Annual Scientific Meeting were reviewed and included in the analysis: 20 oral presentations, 26 oral posters, 8 podium videos, and 21 videofest videos. The median character and word counts for oral presentation titles were 95 and 13, for oral poster titles 91 and 14, and for video titles 62 and 9, respectively. The mean introduction time was 13.5 seconds. The mean times to verbalize titles for oral, oral poster and video presentations using median character count was 10.3, 9.5, and 8.1 seconds. The mean times to verbalize titles for oral, oral poster and video presentations using median word count was 7.4, 10.1, and 7.35 seconds. The resultant total time of seventy-five presentations using the standard script for introductions and the average character count of the titles is 3105 seconds (51.8 minutes). Similarly, the total time using the average word count is 2876.25 seconds (47.9 minutes). A mean of 49.85 minutes could be saved if these statements were omitted.
CONCLUSION: Fifty minutes, almost 1 hour, could be saved if self-introductions and general pleasantries were omitted from the SGS Annual Scientific Meeting. This could be utilized to allow additional research presentations, social activities or to wait in line at Space Mountain. Let's be honest, we are all thankful to the society for hosting an outstanding annual meeting and allowing us to present our research, however, self-introductions and pleasantries may not be necessary. We believe our findings are generalizable and may be applied to other scientific/clinical meetings within and outside our surgical specialty.

DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS: Jennifer Schmitt: Nothing to disclose; John Gebhart: Elsevier, Inc., Author, Royalties; UpToDate, Inc., Author, Royalties; John A. Occhino: Nothing to disclose.

99 Robot-assisted hysterectomy: Comparison between the three-port and multiport techniques across uterine weights

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OBJECTIVES: To assess the safety and feasibility of the three-port robotic hysterectomy.
MATERIALS AND METHODS: Retrospective cohort study including patients undergoing three-port and multiport hysterectomy from January 2012 to December 2016 at an urban university hospital center by fellowship trained minimally invasive gynecologic surgeons (N=141). The patients were stratified into three groups based on postoperative uterine weight <250 g, 250-500 g, and >500 g. All pre-operative and operative characteristics were collected. Similarly, all intraoperative and postoperative complications were gathered for analysis.
RESULTS: A total of 141 consecutive patients undergoing robotic-assisted hysterectomy were selected. Procedures requiring ≥4 ports (including the camera port) were labeled as "multiport"; surgeries done through 3 ports (including the camera port) were labeled as "three-port." Baseline characteristics of the 250-500g and the >500g groups were compared to the <250g group. The populations were homogenous for baseline demographics, surgical history and concomitant procedures at the time of hysterectomy. To assess the safety and feasibility of the three-port hysterectomy across uterine weights appropriate regression models were used for the following 5 outcomes; Intraoperative and postoperative complications, estimated blood loss, operative time, and length of hospital stay. Uterine weight, number of prior surgeries and number of concomitant procedure were controlled as covariate. Based on the regression analysis, the operative time is increased by 0.0386 (95% CI: 0.0249-0.0523) minutes per gram increase in uterine weight. The estimated blood loss also increases by 0.0501 (95% CI: 0.0171-0.0831) mL per gram increase in uterine weight. No significant association was found between uterine weight and intraoperative or postoperative complications. This this due to a lack of power based on the small number of events. The length of stay in the hospital was not significantly changed across the three groups (250-500 group, RR 0.7, p=0.6), (>500g group, RR 1.08, p=0.9) further reinforcing the safety of the procedure across uterine weights.
CONCLUSION: Three-port robotic hysterectomy appears to be equivalent across uterine weights to its multiport counterpart. The decision to insert an assistant port should be based on factors other than the uterine weight.

DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS: Gaby Moawad: Applied Medical, Speaker, Honorarium; Intuitive Surgical, Speaker, Honorarium; Elias Abi Khalil: Nothing to disclose; Paul Tyan: Nothing to disclose.

100 Reevaluating the effectiveness of single incision midurethral slings

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OBJECTIVES: To evaluate effectiveness and complication rates when using single incision midurethral sling.
MATERIALS AND METHODS: We conducted a retrospective cohort study of all patients who had a suburethral sling but looked specifically at those who had an Altis single incision sling from January 2015 to January 2017 with at least 6 months of post-operative data available. Eligible patients were identified using current procedural terminology (CPT) codes. Medical records including preoperative and postoperative visits as well as operative reports were reviewed and data collected. Sling failures were identified based on patient report of stress incontinence symptoms or a positive empty supine stress test documented at a postoperative visit. Complications including mesh erosion, new or worsened urgency or urge incontinence, urinary retention, postoperative or recurrent UTI or pain were identified based on documentation in patient medical records or operative notes All surgeries were performed by one of four board certified FPMRS surgeons in our practice along with FPMRS fellows.
RESULTS: A total of 52 patients who underwent single incision midurethral slings were identified based on CPT codes. Of those women, 14 were excluded as they did not have at least 6 months of